VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 14, 2010

James Sutton, Administrator
Victorian House Residence At Cedar Hill
49 Cedar Hill Drive
Windsor, VT 05089

Dear Mr. Sutton:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on **October 26, 2010.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0293	A. BUILDING _____ B. WING _____	C 10/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN HOUSE RESIDENCE AT CEDAR HI	49 CEDAR HILL DRIVE WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite licensing survey and complaint investigation was initiated by the Division of Licensing and Protection on 10/25/10 and concluded on 10/26/10.	R100		
R101 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Per observation, record review and interview, the home retained and/or admitted 3 residents (Resident #1, Resident #3, and Resident #5) whose care needs exceed that which the home is licensed to and/or has the capacity to provide. Findings include: 1. Per record review on 10/25/2010, Resident #1 exhibited physical and mental declines including inability to move freely within the environment, inability to perform activities of daily living, increased anxiety/aggression/combativeness requiring medical intervention, and falls since admission. Per observations throughout the day on 10/25/2010 and the morning of 10/26/2010, Resident #1 was not able to rise independently from a chair, frequently called out for assistance and was assisted by staff with all activities of daily living. During interview, the Director of Nursing confirmed that Resident #1 has experienced a significant change in physical and mental abilities	R101	**R101** **Resident Care and Home Services** **Eligibility** Resident #1 was moved to Long Term Care Unit on October 26, 2010. Resident #3 was discharged to Dartmouth Hitchcock Hospital on September 5, 2010 and died. Resident #5 a LOC variance as needed will be requested promptly. Measures put in place to prevent this deficient practice from recurring are 1) Resident screening by an RN and admissions nurse with signatures of both nurses agreeing to appropriateness for Victorian House residency. R101 12-13-10 POC accepted as written. — C. Lanaway, RN	

James B Hutton
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR

(X6) DATE: 12-8-2010

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R101	Continued From page 1 following admission, that a written 30-day notice to discharge/transfer has not been delivered to either the resident or responsible party, that Resident #1 exceeds level of care for the Residential Care Home, and that a level of care variance has not been sought to retain the resident. 2. Per record review on 10/25/2010, Resident #3 was admitted requiring assistance with walking, transfer from bed to chair, wheelchair mobility and required full assistance with dressing, bathing, showering and toileting/hygiene per pre-admission family questionnaire. Per physician statement dated 9/3/2010, Resident is "significantly impaired with ADLs" (Activities of Daily Living). During interview at 2:00 PM on 10/26/2010, the Director of Nursing confirmed that a variance had not been obtained prior to admitting Resident #3 whose needs exceeded Level III care. 3. Per observation on 10/25/2010 and 10/26/2010, Resident #5 was observed to be unable to independently propel his/her wheelchair due to loss of function of one side of the body. During interview on the afternoon of 10/26/2010, the Director of Nursing confirmed that this resident is unable to independently evacuate the second floor living residence without physical assistance, exceeding the home's licensed level of care. No level of care variance has been obtained to retain this resident.	R101	These measures will be monitored so this deficient practice does not recur by presenting them in daily admissions meeting with open discussion of appropriateness of resident meeting the criteria to reside in Victorian House. The resident admissions in the Victorian House will be reviewed in Quality Assurance meeting quarterly. Completion Date: January 10, 2011 R101 12-13-10 POC accepted as written. — C. Lanaway, RN	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a	R126		

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R126	Continued From page 2 residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, 1 applicable resident in the survey did not have evidence of care provision to meet personal and medical needs regarding accidents/falls. (Resident #3) Findings include: 1. Per record review on 10/25/2010, Resident #3 had fallen on 8/31/2010, 9/1/2010, and 9/5/2010. There was no indication that the family/responsible party had been notified following the falls on 8/31/2010 and 9/1/2010. There was no documented physician notification following any of the 3 falls. During interview on 10/26/2010 at 2:00 PM, the Director of Nursing confirmed that family/responsible parties and the physician should be notified following a fall and that this was not completed as indicated above.	R126	**R126** **Resident Care and Home Services** **General Care** Resident #3 has been discharged from Victorian House and is deceased. Policy and procedure is in place, and a new form has been designed to fill out by staff on contacting physician, family and follow through for 72 hours. The Director of Nursing/RN will be notified within 4 hours of the fall. This corrective action will be monitored by RN/Director of Nursing in charge of the Victorian House receiving the completed form at the end of the 72 hours. The Quality Assurance meeting will review these forms and be updated on their effectiveness. Completion Date: January 10, 2011 R126 12-13-10 POC accepted as written. — C. Laraway, RN	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary.	R134		

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R134	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to complete an assessment within 14 days of admission for 2 of 4 residents (Resident #1 and Resident #2) in the sample. Findings include: 1. Per record review, Resident #1 was admitted on 5/1/10 and the assessment was completed and signed by a Registered Nurse (RN) on 5/24/10. The Director of Nurses confirmed the late assessment completion date on 10/26/10 at 10:40 AM. 2. Per record review, Resident #2 was admitted on 8/2/10 and the assessment was completed and signed by an RN on 9/6/10. The Director of Nurses confirmed the late assessment completion date on 10/26/10 at 10:40 AM.	R134	**R134** **Resident Care and Home Services** **Assessment** Assessments will be completed within the first 14 days of admission, a tracking system is put in place for the first 30 days of admission and tracking systems for re-assessment to be completed appropriately. All assessments for current residents will be reviewed for appropriate placement. This will be monitored by the DNS/RN and at quarterly Quality Assurance meeting. Completion Date: January 10, 2011 R134 12-13-10 POC accepted as written. — C. Laraway, RN	
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the nurse failed to perform a re-assessment for 1 of 4 applicable residents (Resident #1) at a point when there was a significant change in the resident's physical and mental condition. Findings include:	R136		

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R136	Continued From page 4 1. Per record review, an assessment for Resident #1 was completed and signed by the nurse on 5/24/10. The assessment indicated that Resident #1 required minimal assist to transfer and ambulate with a walker, and was prescribed no psychoactive medications. On 7/6/2010 the resident attended psychological counseling for "losses, decline" per progress note. Per review of physician orders and the Medication Administration Record (MAR), Resident #1 began receiving Lorazepam (which is a psychoactive medication) twice daily beginning 10/15/10 to address behavioral symptoms. Additionally, it was documented that Resident #1 had five falls during attempts to transfer or ambulate from 10/22/10 to 10/25/10. Per observation on 10/25/10 at 4:45 PM, Resident #1 required extensive assistance and use of a gait belt while rising from a chair to the walker, and to ambulate to the elevator with continued physical assistance and verbal cuing. Per interview on 10/26/10 at 8:30 AM, the Director of Nurses confirmed the decline of function.	R136	**R136** **Resident Care and Home Services** **Assessment** Resident #1 has been moved to Long Term Care on October 26, 2010. Residents will be reviewed weekly on appropriateness of level of care for the Victorian House. A weekly form will be designed by the DNS/RN on each resident monitoring for changes in level of care This will be monitored by DNS/RN and quarterly Quality Assurance meeting Completion Date: January 10, 2011 R136 12-13-10 POC accepted as written. — C. Laraway, RN	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the	R145		

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R145	Continued From page 5 Registered Nurse (RN) failed to oversee the development and/or revision of a written plan of care based on abilities and needs of 4 of 4 applicable residents (Resident #1, Resident #2, Resident #3, and Resident #4). Findings include: 1. Per record review, physician orders for Resident #2 specify that staff assist with colostomy care on each shift and as needed. Per review of the resident care plan dated 9/7/10, staff are directed to assist the resident with colostomy care only prior to sleep in the evening. The Director of Nursing (DON) confirmed inconsistencies between the medical orders and written plan of care during an interview on 10/26/10 at 11:20 AM. 2. Per review of physician orders, Resident #2 was prescribed Risperdal (a psychoactive medication) on 9/30/10. The written plan of care dated 9/7/10 was not revised to reflect the addition of a psychoactive medication. The Director of Nursing (DON) confirmed inconsistencies between the medical orders and written plan of care during an interview on 10/26/10 at 11:20 AM. 3. Per record review on 10/26/2010, there was no plan of care directing staff in the care of Resident #3 regarding fall risk and interventions to reduce falls and/or injury. During interview on 10/26/2010 at 10:30 AM, the DON confirmed that the plan of care for Resident #3 did not include interventions to address identified fall risks. 4. Per record review on 10/26/2010, Resident #4 experiences daily pain due to arthritis/degenerative joint disease and receives Acetaminophen 1000 mg (milligrams) TID (three times daily). The plan of care for Resident #4	R145	**R145** **Resident Care and Home Services** **Oversee development of written care plan** Resident #2 whose physicians orders specify assistance with colostomy care on every shift, has had her care plan updated and clarification with resident and family. Risperdal care plan is updated to reflect current medication and behavioral plan. Resident #3 is no longer a resident at the Victorian House. Resident #4 care plan has been updated to address pain management. Resident #1 has been transferred to the Long Term Care facility. R145 12-13-10 PoC accepted as written. — C. Laraway, RN —	

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R145	Continued From page 6 does not direct staff in pain management strategies for this resident. During interview on the late morning of 10/26/2010, the DON confirmed that the plan of care did not identify pain as an issue for this resident and that it did not instruct staff regarding monitoring and management strategies. 5. Per review of the Medication Administration Record (MAR), Resident #1 was administered an as needed (PRN) dose of Lorazepam at 3:40 AM on 10/26/10. There was no written care plan regarding as needed administration of a psychoactive medication for Resident #1. Per interview on 10/26/10 the Director of Nurses confirmed that the written plan of care lacked a directive for the use of as needed Lorazepam (ordered 10/15/10), per facility policy.	R145	Measures put in place to prevent these deficient practices are all care plans will be reviewed by DNS/RN on a weekly basis to assure they have been updated appropriately with medication orders, incidents, and ADLs. A Form has been designed to give the DNS/RN a weekly picture of each resident. This will be reviewed quarterly at the Quality Assurance Meeting. Completion Date: January 10, 2011 R145 12-13-10 POC accepted. C. Lavanway, RN	
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not maintain a current medication list for 1 of 4 residents in the survey sample (Resident #4). Findings include: 1. Per record review on 10/26/2010, the standing orders for Resident #4 were dated 10/14/2008	R147	**R147** **Resident Care and Home Services** **Medication Review List** Resident #4, medication standing orders have been reviewed and updated appropriately with Physicians Signatures. Audit of all Victorian House Residents with Standing Orders have been updated appropriately and signed and dated by the resident's physician.	

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R147	Continued From page 7 and were signed by a physician not identified as a current physician for Resident #4. During interview on 10/26/2010 at 11:15 AM, the Director of Nursing confirmed that the standing orders in the record of Resident #4 were not signed by the current physician.	R147	This will be reviewed by the Medical Director and monitored at the quarterly Quality Assurance Meeting. Completion Date: January 10, 2011 R147 12-13-10 POC accepted as written. — C. Laraway, RN	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Registered Nurse (RN) failed to develop a written plan describing specific behaviors, circumstances and monitoring of side effects, for PRN (as needed) psychoactive medications administered by unlicensed staff, for 2 of 4 applicable residents (Resident #1 and Resident #2) in the sample. Findings include: 1. Per record review, a medical order was written	R167	**R167** **Resident Care and Home Services** **Medication Management** Resident #1 has moved to Long Term Care on October 26, 2010. DNS/RN will audit all residents PRN medications and update with written interventions and care plans to assure proper care of resident. This will be monitored on a weekly basis by the DNS/RN with quarterly Quality Assurance review. Completion Date: January 10, 2011 R167 12-13-10 POC accepted as written. — C. Laraway, RN	

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R167	Continued From page 8 9/30/10 for Risperdal (a psychoactive medication) 0.5 mg, 1 tablet given by mouth daily as needed for (PRN) agitation. The written care plan of Resident #2 showed no evidence of directives to guide staff in using the medication for specific behavioral symptoms, nor in monitoring medication side effects following administration. During an interview on 10/26/10 at 10:35 AM, the Director of Nurses confirmed that the written care plan for Resident #2 lacked directives regarding PRN administration of psychoactive medication. 2. Per record review, a medical order was written 10/15/10 for Lorazepam (a psychoactive medication) 0.25 mg by mouth PRN agitation, combativeness, and anxiety. The written plan of care for Resident #1 showed no evidence of directives to guide staff in identifying targeted behaviors or in monitoring medication effects following administration. During an interview on 10/26/10 at 10:35 AM, the Director of Nurses confirmed that the written care plan for Resident #1 lacked directives regarding PRN administration of psychoactive medication.	R167		
R171 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications,	R171	**R171** **Resident Care and Home Services** **Medication Management** Current list of unlicensed staff that received certification to give medication has been updated as of December 3, 2010 and placed in front of the Medical Administration Records. The DNS will update and monitor this list as new certified unlicensed staff becomes trained to administer medication. This will be reviewed at quarterly Quality Assurance meeting. Completion Date: January 10, 2011 R171 12-13-10 POC accepted as written. — C. Lavaway, RN	

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R171	Continued From page 9 including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) did not assure that a current list of staff delegated to administer medication was available for review. Findings include: 1. Per record review on 10/25/2010, there was no current list identifying unlicensed staff delegated by the RN to administer and/or assist residents with medications. During interview on the afternoon of 10/25/2010, the Director of Nursing confirmed that the available list of medication delegated, non-licensed staff is not current.	R171		
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the	R173		

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R173	Continued From page 10 keys This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to assure that all managed medications are stored in locked compartments. Findings include: 1. Per observation during initial tour on 10/25/2010, an unsecured bottle of Travoprast ophthalmic solution 0.0004% was on the refrigerator door. At the time of the observation, the Manager confirmed that this medication was on the door and should have been in the lock box within the refrigerator. 2. Per observation on 10/25/2010 and 10/26/2010, the stock medication cabinet in the nursing station area had a padlock in place but was not securely clicked/locked. During interview on 10/26/2010 at 9:50 AM, the Manager confirmed that this cabinet was accessible to residents, that it was unlocked and per policy, the cabinet is to be kept locked at all times.	R173	**R173** **Resident Care and Home Services** **Medication Management** A sign off sheet has been placed in front of the Medical Administration Records to be signed off by each on coming and off going staff member to assure the cabinet and medications in the refrigerator are appropriately stored. Sign off sheet will be monitored weekly for appropriate signatures with periodic checks by the DNS/RN for storage and securing of cabinet. The Victorian House staff will be in-serviced on this process and this will be reviewed at the Quality Assurance meeting quarterly. Completion Date: January 10, 2011 R173 12-13-10 POC accepted as written. — C. Larrow, RN	
R178 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home	R178		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	Continued From page 11 does not ensure the presence of an RN (Registered Nurse) within the Residential Care Home (RCH) on a routine, scheduled basis. Findings include: 1. Per record review on 10/25/2010, the staff schedule does not include the presence of an RN on the RCH unit on a weekly basis. The record indicates that the home has 2 of 11 current residents (Resident #2 and Resident #4) receiving ERC (Enhanced Residential Care) funding, which requires the presence of an RN for 1 hour per resident per week to perform assessments, care and service planning. During interview on 10/25/2010 at 10:55 AM, the DON (Director of Nursing) confirmed that nursing time is not scheduled for the home for either the ERC residents or for residents with other funding sources. S/he stated that nursing service is provided by the DON and other nurses from the attached nursing home on an as needed basis.	R178	**R178** **Resident Care and Home Services** **Staff Services** DNS/RN will schedule a RN to work in the Victorian House weekly for approximately 5 hours and prn with a RN or LPN on call 24/7. Signature notebook will be used to sign in and out when working in the Victorian House. This will be reviewed and updated weekly by the DNS so appropriate hours are maintained. This will be reviewed at the quarterly Quality Assurance meeting. Completion Date: January 10, 2011 R178 12-13-10 POC accepted as written. — C. Lanaway, RN	
R187 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (1) A resident register including all discharges, transfers out of the home and admissions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not produce a complete resident register for review by the survey team. Findings include: 1. Per record review on 10/25/2010, there was no resident register identifying all resident discharges, transfers out of the home and admissions. During interview at 10:00 AM on	R187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0293	A. BUILDING _____ B. WING _____	C 10/26/2010

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R187	Continued From page 12 10/25/2010, the Manager stated s/he had no written resident register. Two 'resident roster' documents were provided on 10/25/2010 by the Administrator, but neither contained all required transfer/discharge information. On the afternoon of 10/26/2010, the Director of Nursing indicated that s/he was aware of the presence of the resident register and would produce for review by surveyors. No register was submitted for review during the onsite survey.	R187	**R187** **Resident Care and Home Services** **Resident Register** Resident Register is available and onsite in the Social Service/Admissions office. Victorian House Manager will be updated as to where it is kept. Completion Date: January 10, 2011	R187 12-13-10 POC accepted as written, C. Lavaway, RN
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not develop and implement policies and procedures regarding resident falls and accidents. Findings include: 1. Per record review on 10/26/2010, the home has no written policy and procedure available to instruct staff regarding care and services related to resident falls and accidents. During interview on 10/26/2010, the DON (Director of Nursing) confirmed that there was no written policy and procedure instructing staff regarding resident falls with or without injury) at the Residential Care Home.	R200	**R200** **Resident Care and Home Services** **Policies and Procedures** A written policy and procedure for falls and incident reports will be put in place. In-servicing with the Victorian House staff on proper completion of incident reports following the policy and procedure. Policy and Procedure will be reviewed by the Quality Assurance Committee. Completion Date: January 10, 2011	R200 12-13-10 POC accepted as written, C. Lavaway, RN